EXHIBIT 1

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IN THE UNITED STATES DISTRICT COURT
STATE OF UTAH, CENTRAL DIVISION

CYNTHIA STELLA, and the ESTATE OF HEATHER MILLER, Plaintiffs, vs. DAVIS COUNTY, SHERIFF TODD RICHARDSON, MAVIN ANDERSON, JAMES ONDRICEK Defendants.	**DECLARATION OF DEBORAH SCHULTZ IN SUPPORT OF MOTION FOR PARTIAL SUMMARY JUDGMENT [DN 31]** Case No: 1:18-cv-002 Judge: Jill Parrish

I, Deborah Schultz, declare:

1. Attached as Exhibit A is a true and accurate copy of my bio and CV.
2. Attached as Exhibit B is a true and accurate copy of my expert opinion provided to Plaintiffs' Counsel.

3. Prior to issuing my opinion. I reviewed both parties' initial disclosures, Davis County's response to Plaintiffs' first set of discovery, and the Attorney General's response to Plaintiffs' subpoena.

4. I am a Registered Nurse with a current California nursing license, and in good standing with the California Board of Registered Nurses since 1983. As of September 2012, I have been conducting Detention Facility Audits/Inspections for the Santa Barbara County Public Health Department. My audits include 15 facilities annually, and on occasion, follow up inspections for infraction corrections.

5. If called to testify at trial, I would testify to the facts and opinions contained in Exhibit B. Specifically, I would testify to the following:

SUMMARY:

6. December 20, 2016 at 0419 hours-Heather Miller is booked into the Davis County Jail on drug charges after traffic stop by the Davis County Sheriff Department.

7. Initial Medical Screening sheet completed, noting No medical conditions.

8. At 1413- Health Assessment form/Intake sheet completed by Jaime Hatch, R.N., noting No medical concerns.

9. December 21, 2016 at 1756 hours- it was reported that Heather fell from her top bunk.

10. At 1800 hours- Nurse Marvin Anderson arrives to assess Heather after her fall, which consisted of a brief interview and visual assessment of Heather, but no vital signs taken or equipment brought to take them.

11. Heather moved to another unit via wheel chair for medical check and bottom bunk placement.

12. At 2020 hours- Heather found partially clothed on cell floor "thrashing about" with a new laceration under her chin. Medical called, but did not revisit Heather in her cell for reassessment of her medical status.

13. At 2030 hours- Sergeant Wall was requested to evaluate situation with Heather stating "I hurt everywhere." Sergeant Wall was able to get Heather transferred to the medical unit, via wheel chair and officers assistance.

14. At 2039 hours- Nurse Marvin Anderson unable to obtain vital signs on Heather again, this time due to her thrashing about, and Nurse Anderson reports Heather is gray and pale, (according to his deposition).

15. At 2103 hours- Heather is transported to McKay Dee Hospital. While en route, CPR and defibrillation is required.

16. At 2206 hours- Heather Miller is pronounced dead.

17. After reviewing the depositions and timelines of this unfortunate and tragic death of Heather Miller, I would state that basic nursing practices/management of the situation were not followed. For Nurse Marvin Anderson to admittedly state that the vital signs were not taken after arriving at the scene of Heather Miller's fall from a top bunk is a complete disregard to Utah's Nurse Practice Act as stated.

UTAH NURSE PRACTICE ACT

18. R156-31b-703b. Scope of Nursing Practice Implementation:

> (e) demonstrate appropriate decision making, critical thinking, and clinical judgment to make independent nursing decisions and to identify health care needs;
>
> (f) correctly identify changes in each patient's health status;

(g) comprehend clinical implications of patient signs, symptoms, and changes as part of ongoing or emergent situations;

(h) critically evaluate the impact of nursing care, the patient's response to therapy, and the need for alternative interventions;

(k) communicate with other health team members regarding patient choices, concerns, and special needs, including:

(i) patient status and progress;

(ii) patient response or lack of response to therapies; and

(iii) significant changes in patient condition

OPINION

19. I believe Nurse Marvin Anderson is in violation of Utah's Nurse Practice Act. He has demonstrated inappropriate decision making, poor critical thinking, poor clinical judgement, unable to identify health care needs, unable to identify changes in patient status, and lack of communication with other health team members.

20. The simple task of taking a blood pressure, pulse, and respiratory rate could have indicated a potential problem was evolving, especially after comparing those results with the intake vital signs sheet, which indicated normal vital signs on admission to the Davis County Jail.

21. By doing so, Nurse Anderson would have established a baseline reading of vital signs for Heather after her fall off the top bunk.

22. With subsequent rechecks of her vital signs, Nurse Anderson could have recognized a decline in Heather's medical condition indicated by a dropping blood pressure, increasing pulse rate, increasing respiratory rate, and change of her mental status as noted by her " thrashing around".

23. According to the autopsy report, Heather Miller's death was due to internal exsanguination, or bleeding out.

24. I believe with careful monitoring, her deteriorating condition, through vital sign checks and level of consciousness checks, would have alerted the medical staff to intervene sooner

25. I would also note that any patient who requires the need to be transported via wheel chair after a fall from the top bunk, should be an obvious indication that further evaluation is necessary, especially when prior to the fall, Heather was able to walk under her own volition. Again, this show complete disregard for Heather's wellbeing, and lack of sound nursing judgement.

VITAL SIGNS

26. Pusle- An index of the heart's rate, rhythm, condition of arterial walls, compressibility and tension, and size and shape of the fluid wave of blood traveling through the arteries as a result of each heartbeat. The pulse can be faster, for example in anemic or hypovolemic persons, persons in shock, and patients who have taken drugs that stimulate the heart. The pulse quality is determined by the amount of blood pumped through the peripheral arteries.

27. Blood Pressure- The heart generates pressure during the cardiac cycle to perfuse the organs of the body with blood. The tension exerted on the walls of arteries by the strength of the contraction of the heart; the resistance of arterioles and capillaries; the elasticity of blood vessel: blood volume. Low blood pressure can indicate blood volume loss.

28. Respiration- Is the process of bringing oxygen to body tissues and removing carbon dioxide. The quality of breathing is an important vital sign baseline assessment. Need to evaluate the pattern, rate, depth of breathing to observe the physical characteristics of chest expansion.

29. Hypovolemia- A decreased circulation blood volume that may be caused by internal or external bleeding. Signs and symptoms of hypovolemia= Rapid pulse, Changes in breathing patterns, profuse sweating, dizziness, alteration in heart rhythm or rate, and alteration in mental status.

30. It is in my professional opinion that virtually no medical care was administered by Nurse Marvin Anderson to Heather Miller after her fall from the top bunk, demonstrating complete disregard for Utah's Nurse Practice Act.

31. Nurse Anderson and the jail staff failed to act on the behalf of Heather Miller's best interest, even with the glaring symptoms of an injury present.

32. Nurse Anderson's actions, or should I say lack of actions, could also be construed as medical malpractice.

33. I believe by providing no medical care to Heather Miller while incarcerated at the Davis County Jail, contributed to her early and untimely death.

I declare under penalty of perjury in the State of Utah that the foregoing is true and correct.

Executed on May 15 2019 in ~~Utah~~ California

Deborah Schultz

Deborah Schultz

EXHIBIT A

DEBORAH SCHULTZ, R.N.

Community Health Nurse in the Immunization Program
Santa Barbara County Public Health Department
2115 S. Centerpointe Parkway Room 220
Santa Maria, CA 93455
Phone: (805) 346-8472
Fax: (805) 346-8472
Cell: (805) 857-0534

Email: deborah.schultz@sbcphd.org, queenieds@charter.net

Education

LAC/USC School of Nursing 1981-1983, Registered Nurse
LAC/USC Critical Care Certification 1983
Glendale Adventist College, 1985 Dialysis Training

Honors and Awards

2016 Outstanding Effort Award, California Department of Public Health

Licensure/certifications

09/1983 to present. Registered Nurse, California Board of Registered Nursing. License # 362329

09/1983 to present. Basic Life Support Provider: American Heart Association.

06/1984 to 06/1988. Critical Care Registered Nurse, California Board of Registered Nurse.

Professional Experience

09/2009 to present. Registered Nurse at the Santa Barbara County Public Health Department, Communicable disease and Immunization Departments.

09/2012 to present. Santa Barbara County Public Health Department/Probation Department Detention Facilities Auditor.

10/1992 to present. Medical Volunteer for Nazarene Church including medical trips to Peru and India.

03/2009 to 09/2009. Per Diem Registered Nurse at the Santa Maria Juvenile Hall.

08/1989 to 08/1990. Registered Nurse at the San Luis Obispo County Jail.

10/1988 to 10/1989. Critical Care Instructor at San Luis Obispo General Hospital.

04/1987 to 10/1988. Critical Care Registered Nurse in the ICU at Sierra Vista Hospital, San Luis Obispo, California.

12/1983 to 07/1987. Critical Care Nurse at LAC/USC Medical Center, Neuro-Surgical Unit, Los Angeles, California.

12/1983 to 07/1987. Critical Care Nurse at LAC/USC Medical Center, Float Pool, Los Angeles, California.

08/1983 to 12/1983. Registered Nurse at LAC/USC Medical Center, Neuro Surgical Floor 5300, Los Angeles, California.

19/1981 to 06/1983. LAC/USC Medical Center Student Nurse Worker, Los Angeles , California.

EXHIBIT B

Tad D. Draper, PC
The Law Offices of Tad D. Draper
12339 S. 800 E. Ste. 101
Draper, UT. 84020-8373

Mr. Draper,

Thank you for the opportunity to review this case. I am a Registered Nurse with a current California nursing license, and in good standing with the California Board of Registered Nurses since 1983. As of September 2012, I have been conducting Detention Facility Audits/Inspections for the Santa Barbara County Public Health Department. My audits include 15 facilities annually, and on occasion, follow up inspections for infraction corrections.

As a Detention Facility Auditor, one of the first items I require to see at any facility that I am auditing is the Policy and Procedure Manual. I then ask the nurses and correctional officers to demonstrate to me that he/she can find policies and procedures regarding the potential situations I create. It is disturbing to me that no such manual has been produced from the Davis County Jail.

Timeline of events:

- December 20, 2016 at 0419 hours-Heather Miller is booked into the Davis County Jail on drug charges after traffic stop by the Davis County Sheriff Department
- Initial Medical Screening sheet completed, noting No medical conditions
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- At 1800 hours- Nurse Marvin Anderson arrives to assess Heather after her fall, which consisted of a brief interview and visual assessment of Heather, but no vital signs taken or equipment brought to take them.
- Heather moved to another unit via wheel chair for medical check and bottom bunk placement
- At 2020 hours- Heather found partially clothed on cell floor “thrashing about” with a new laceration under her chin. Medical called, but did not revisit Heather in her cell for reassessment of her medical status.
- At 2030 hours- Sergeant Wall was requested to evaluate situation with Heather stating “I hurt everywhere.” Sergeant Wall was able to get Heather transferred to the medical unit, via wheel chair and officers assistance.
- At 2039 hours- Nurse Marvin Anderson unable to obtain vital signs on Heather again, this time due to her thrashing about, and Nurse Anderson reports Heather is gray and pale, (according to his deposition).
- At 2043 hours- 911 called
- At 2049 hours- EMS arrive

- At 2103 hours- Heather is transported to McKay Dee Hospital. While en route, CPR and defibrillation is required.
- At 2206 hours- Heather Miller is pronounced dead.

After reviewing the depositions and timelines of this unfortunate and tragic death of Heather Miller, I would state that basic nursing practices/management of the situation were not followed. For Nurse Marvin Anderson to admittedly state that the vital signs were not taken after arriving at the scene of Heather Miller's fall from a top bunk is a complete disregard to Utah's Nurse Practice Act as stated:

Utah Nurse Practice Act

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(k) communicate with other health team members regarding patient choices, concerns, and special needs, including:
(i) patient status and progress;
(ii) patient response or lack of response to therapies; and
(iii) significant changes in patient condition

I believe Nurse Marvin Anderson is in violation of Utah's Nurse Practice Act. He has demonstrated inappropriate decision making, poor critical thinking, poor clinical judgement, unable to identify health care needs, unable to identify changes in patient status, and lack of communication with other health team members.

The simple task of taking a blood pressure, pulse, and respiratory rate could have indicated a potential problem was evolving, especially after comparing those results with the intake vital signs sheet, which indicated normal vital signs on admission to the Davis County Jail. By doing so, Nurse Anderson would have established a baseline reading of vital signs for Heather after her fall off the top bunk. With subsequent rechecks of her vital signs, Nurse Anderson could have recognized a decline in Heather's medical condition indicated by a dropping blood pressure, increasing pulse rate, increasing respiratory rate, and change of her mental status as noted by her " thrashing around". According to the autopsy report, Heather Miller's death was due to internal exsanguination, or bleeding out. I believe with careful monitoring, her deteriorating condition, through vital sign checks and level of consciousness checks, would have alerted the medical staff to intervene sooner. I would also note that any patient who requires the need to be transported via wheel chair after a fall from the top bunk, should be an obvious indication that further evaluation is necessary, especially when prior to the fall, Heather was able to

walk under her own volition. Again, this show complete disregard for Heather's wellbeing, and lack of sound nursing judgement.

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2. Blood Pressure- The heart generates pressure during the cardiac cycle to perfuse the organs of the body with blood. The tension exerted on the walls of arteries by the strength of the contraction of the heart; the resistance of arterioles and capillaries; the elasticity of blood vessel: blood volume. Low blood pressure can indicate blood volume loss.
3. Respiration- Is the process of bringing oxygen to body tissues and removing carbon dioxide. The quality of breathing is an important vital sign baseline assessment. Need to evaluate the pattern, rate, depth of breathing to observe the physical characteristics of chest expansion.
4. Hypovolemia- A decreased circulation blood volume that may be caused by internal or external bleeding. Signs and symptoms of hypovolemia= Rapid pulse, Changes in breathing patterns, profuse sweating, dizziness, alteration in heart rhythm or rate, and alteration in mental status.

It is in my professional opinion that virtually no medical care was administered by Nurse Marvin Anderson to Heather Miller after her fall from the top bunk, demonstrating complete disregard for Utah's Nurse Practice Act. Nurse Anderson and the jail staff failed to act on the behalf of Heather Miller's best interest, even with the glaring symptoms of an injury present. Nurse Anderson's actions, or should I say lack of actions, could also be construed as medical malpractice. I believe by providing no medical care to Heather Miller while incarcerated at the Davis County Jail, contributed to her early and untimely death.

Respectfully submitted,

Deborah Schultz, R.N.